

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-033195

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 278 Primary Registration District No. 3054 Registrar's No. 116
FILED SEP 11 1963

VS 300
Rev. 4/59

1 0822
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DATE AMENDED

INSTEAD OF

SHOULD READ

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pike</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Louisiana</u>		c. CITY OR TOWN <u>Louisiana</u>	
Length of stay in lb <u>74 yrs.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>722 North 8 th.</u>		d. STREET ADDRESS (If outside, give location) <u>722 North 8 th.</u>	
3. NAME OF DECEASED (Type or print) First <u>Nellie</u> Middle <u>Thelia</u> Last <u>Washington</u>		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7/29/1889</u>
9. AGE (last birthday) <u>74</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HR Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>County Hospital</u>	
11a. BIRTHPLACE (City and state or country) <u>Pike County Missouri</u>		11b. NAME OF HUSBAND OR WIFE <u>Bert Washington</u>	
13a. FATHER'S NAME <u>Jim Brice</u>		13b. MOTHER'S MAIDEN NAME <u>Mary Caldwell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Margie Dutton Louisiana Mo.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for each of the three lines) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary paralysis</u>		INTERVAL BETWEEN ONSET AND DEATH. <u>1 hour</u>	
DUE TO (b) <u>Thrombotic encephalomalacia with</u>		<u>1 hour</u>	
DUE TO (c) <u>Cerebral Hemorrhage</u>		<u>1 hour</u>	
DUE TO (d) <u>Advanced Arteriosclerosis</u>		<u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <u> </u>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u> </u>	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u> </u>		20f. CITY, TOWN, OR LOCATION <u> </u>	
20g. COUNTY <u> </u>		20h. STATE <u> </u>	
21. I attended the deceased from <u>Dec. 1960</u> to <u>Aug. 1963</u> and last saw <u>her</u> alive on <u>August 20, 1963</u>		Death occurred at <u>11:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <u>Per Y. Broderick, D.O.</u>		22b. ADDRESS <u>218 N. 5th, Louisiana, Mo.</u>	
22c. DATE SIGNED <u>9-7-63</u>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>8/28/63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>	23d. LOCATION (City, town, or county) <u>Louisiana, Missouri</u>
24. FUNERAL DIRECTOR <u>Sterne Funeral Home</u>		25. DATE RECD. BY LOCAL REG. <u>9-9-63</u>	
ADDRESS <u>Louisiana, Mo.</u>		26. REGISTRAR'S SIGNATURE <u>Bernice Collier</u>	

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

J.B. Sterne

Licensed Embalmer No. 4039

P. O. Address

Louisiana Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.